

AMENDED IN SENATE APRIL 21, 2015
AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 137

Introduced by Senator Hernandez

January 26, 2015

An act to add Section 1367.27 to the Health and Safety Code, and to add Section 10133.15 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 137, as amended, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires insurers subject to regulation by the commissioner to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates.

This bill would require health care service plans and insurers subject to regulation by the commissioner for services at alternative rates to make a provider directory available on its Internet Web site and to update the directory weekly. The bill would require the Department of Managed Health Care and the Department of Insurance to develop provider directory standards. By placing additional requirements on

health care service plans, the violation of which is a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1367.27 is added to the Health and Safety
2 Code, to read:
3 1367.27. (a) (1) A health care service plan shall make
4 available a provider directory or directories that shall provide
5 information on contracting providers, including those that accept
6 new patients, pursuant to the requirements of this section and
7 Section 1367.26. A provider directory shall not include information
8 on a provider that does not have a current contract with the plan.
9 (2) A plan shall provide the directory or directories for the
10 specific network offered for each product using a consistent method
11 of network and product naming, numbering, or other classification
12 method that ensures the public, enrollees, potential enrollees, the
13 department, and other state or federal agencies can easily identify
14 which providers participate in which networks for which products.
15 A health plan shall use the same consistent classification method
16 in provider contracts and communications to ensure that providers
17 can identify the products and networks that they are legally
18 contracted to provide services in. The classification shall be
19 consistent across plans in order to permit the department and other
20 state or federal agencies to construct multiplan directories.
21 (3) The provider directory or directories shall be available on
22 the plan's Internet Web site to the public and potential enrollees
23 without any requirement that a member of the public or potential
24 enrollee indicate intent to obtain coverage from the plan. The
25 directory or directories shall be available to the public without
26 requiring that an individual seeking the directory information
27 demonstrate coverage with the plan, provide a policy number,

1 provide any other identifying information, or create or access an
2 account.

3 (b) (1) The provider directory or directories shall be accessible
4 on the plan's public Internet Web site through a clearly identifiable
5 link or tab and in a manner that is accessible and searchable by
6 the public, potential enrollees, enrollees, and providers. The plan's
7 public Internet Web site shall allow for provider searches by name,
8 practice address, National Provider Identification number,
9 California license, facility or identification number, product, tier,
10 provider language, medical group, or independent practice
11 association, hospital, or clinic, as appropriate. If another technology
12 emerges that takes the place of Internet Web sites, the department
13 shall direct the plan to make the information required under this
14 section available on the subsequent technology in a timeframe that
15 allows for implementation of the technology, not to exceed six
16 months. The plan shall also make a paper copy of the directory or
17 directories available upon request.

18 (2) The plan shall update the provider directory or directories,
19 at least weekly, pursuant to paragraph (1) with any change to
20 contracting providers, including all of the following:

21 (A) ~~Instances where~~ *Whether* a contracting provider is no longer
22 accepting new patients, or that the provider moved or relocated
23 from the contracted service area of the plan, or has retired or has
24 otherwise ceased to practice.

25 (B) ~~Instances where~~ *Whether* the contracting provider group, if
26 any, has identified that the provider is no longer associated with
27 the group or is no longer accepting new patients.

28 (C) ~~Instances where~~ *Whether* the plan identified a change based
29 on an enrollee complaint that a provider was not accepting new
30 patients or was otherwise not available.

31 (D) Any other relevant information that has come to the attention
32 of the plan affecting the content of the provider directory.

33 (3) The provider directory or directories shall include both an
34 email address and a telephone number for members of the public
35 and providers to notify the plan if the provider directory
36 information appears to be inaccurate.

37 (4) By September 15, 2016, or no later than six months after
38 the date that provider directory standards are developed under
39 subdivision (d), a plan shall use the developed standards pursuant
40 to subdivision (d) for each product offered by the plan.

(c) A full service health care service plan shall include all of the following information in the provider directory or directories:

(1) The provider's name, ~~location(s)~~ *practice location or locations*, and contact information.

(2) Type of practitioner.

(3) National Provider Identification number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) (A) For physicians, the medical group, if any.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.

(7) Hospital admitting privileges, if any, for physicians and other health professionals contracted with the plan whose scope of services for the plan include admitting patients and who have admitting privileges at a hospital.

(8) Non-English language, if any, spoken by a health professional as well as non-English language, if any, spoken by ~~staff to the provider:~~ *the provider's staff.*

(9) Whether a provider is accepting new patients with the product selected by the enrollee or potential enrollee.

(10) Network tier to which the provider is assigned, if applicable. "Tiered provider network" means a network of participating providers that has been divided into subgroupings differentiated by the health plan according to enrollee cost-sharing levels or quality scores. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

1 (11) A disclosure that ~~enrolles~~ *enrollees* are entitled to full and
2 equal access to covered services, including enrollees with
3 disabilities as required under the Americans with Disabilities Act
4 and Section 504 of the Rehabilitation Act.

5 (12) All other information necessary to conduct a search
6 pursuant to subdivision (b).

7 (d) A specialized health care service plan shall include all of
8 the following information for each of the provider directories used
9 by the plan for its networks:

10 (1) The provider's name, ~~location~~, *practice location or locations*,
11 and contact information.

12 (2) Type of ~~Practitioner~~ *practitioner*.

13 (3) National Provider Identification number.

14 (4) California license number and type of license.

15 (5) The area of specialty, including board certification, if any.

16 (6) If participating in a group practice, the name of the group
17 practice.

18 (7) The names of any allied health care professionals to the
19 extent their services are covered through the contract with the plan.

20 (8) Non-English language, if any, spoken by a health provider
21 as well as non-English language, if any, spoken by *the provider's*
22 staff.

23 (9) Whether a provider is accepting new patients enrolled in the
24 product that the directory applies to.

25 (10) A disclosure that enrollees are entitled to full and equal
26 access to covered services, including enrollees with disabilities as
27 required under the Americans with Disabilities Act and Section
28 504 of the Rehabilitation Act.

29 (e) (1) By March 15, 2016, the department and the Department
30 of Insurance shall develop provider directory standards for purposes
31 of paragraph (3) of subdivision (b).

32 (2) The standards shall be sufficient to permit a single uniform
33 electronic directory that would allow a member of the public to
34 determine whether a physician or other provider is available to an
35 enrollee of the California Health Benefit ~~Exchange as well as~~
36 *Exchange*, a beneficiary of the Medi-Cal program enrolled in a
37 Medi-Cal managed care plan. ~~The standards shall be sufficient to~~
38 ~~permit a single uniform directory that would allow a member of~~
39 ~~the public to determine whether a physician or other provider is~~
40 ~~available to an enrollee with group coverage as well as to a~~

1 beneficiary of the Medi-Cal program enrolled in a Medi-Cal
2 managed care plan or to an enrollee of the California Health Benefit
3 Exchange plan, as well as to an enrollee with group coverage.

4 (3) The department and the Department of Insurance shall seek
5 input from interested parties, including holding at least one public
6 meeting. In developing the directory ~~template~~, *standards*, the
7 department shall take into consideration any requirements for
8 provider directories established by the federal Centers for Medicare
9 and Medicaid Services.

10 (f) (1) The plan shall provide the directory or directories to the
11 department in a format and manner to be specified by the
12 department.

13 (2) The plan shall demonstrate no less than quarterly to the
14 department that the information provided in the provider directory
15 or directories is consistent with the information required under
16 Sections 1367.03 and 1367.035, and other provisions of this
17 chapter. The plan shall assure that other information reported to
18 the department is consistent with the information provided to
19 enrollees, potential enrollees, and the department pursuant to this
20 section.

21 (3) The plan shall demonstrate to the department that enrollees
22 or potential enrollees seeking a provider that is contracted with
23 the network for a particular product can identify these providers
24 and that the provider is accepting new patients. The plan shall
25 ensure that the accuracy of the provider directory meets or exceeds
26 97 percent.

27 (4) The plan shall contact any provider which is listed in the
28 provider directory and which has not submitted a claim within the
29 past three months for primary care providers, or six months for
30 specialty care providers, to determine whether the provider is
31 accepting patients or referrals from the plan, if claims are paid by
32 the plan. If claims are not paid by the plan, the plan shall contact
33 any provider that is listed in the provider directory who has not
34 submitted encounter data within the past three months for primary
35 care providers, or six months without encounter data for a specialty
36 care provider. If the provider does not respond within 30 days, the
37 plan shall remove the provider from the provider directory. This
38 requirement does not apply to claims or encounter data from new
39 primary care providers in the first three months, or new specialty
40 care providers in the first six months, of the contract.

1 (g) The plan shall make available an electronic copy of, or upon
2 request, one physical copy of the provider directory or directories
3 to the following:

4 (1) To the State Department of Health Care Services for
5 Medi-Cal managed care plans.

6 (2) To the California Health Benefit Exchange for the networks
7 of the products offered through the California Health Benefit
8 Exchange, as required by contract.

9 (3) On request by the Public Employees' Retirement System,
10 to the Public Employees' Retirement System.

11 (4) The department and the Department of Insurance.

12 (5) On request by a group purchaser, provider directory or
13 directories for the products available in the market segment of the
14 group.

15 (h) If a contracting provider, or the representative of a
16 contracting provider, informs an enrollee or potential enrollee that
17 the provider is not accepting new patients, the contract between
18 the plan and the provider shall require the provider to *inform the*
19 *plan that the provider is not accepting new patients* and direct the
20 enrollee or potential enrollee to the plan for additional assistance
21 in finding a provider and also to the department to inform it of the
22 possible inaccuracy in the provider directory. If an enrollee or
23 potential enrollee informs a plan of a possible inaccuracy in the
24 provider directory or directories, the plan shall undertake
25 immediate corrective action to ensure the accuracy of the directory
26 or directories.

27 (i) This section does not prohibit a plan from requiring its
28 contracting providers, contracting provider groups, or contracting
29 specialized health care plans to satisfy the requirements of this
30 section. If a plan delegates the responsibility of complying with
31 this section to its contracting providers, contracting provider
32 groups, or contracting specialized health care plans, the plan shall
33 ensure that the requirements of this section are met.

34 (j) Every health care service plan shall ensure processes are in
35 place to allow providers to promptly verify or submit changes to
36 demographic information and participation status. Those processes
37 shall, at a minimum, include an online interface for providers to
38 submit verification or changes electronically and shall allow
39 providers to receive an acknowledgment of receipt from the health
40 care service plan. Providers shall verify or submit changes to

1 demographic information and participation status using this process
2 according to the terms of their contract with the contracted health
3 plan. ~~Providers shall verify or submit changes to demographic~~
4 ~~information and participation status using this process according~~
5 ~~to the terms of their contract with the contracted health plan.~~

6 (k) Every health care service plan shall allow enrollees to request
7 the information required by this section through their toll-free
8 telephone number, electronically, or in writing. On request of an
9 enrollee or potential enrollee, the plan shall provide the information
10 required under subdivisions (a), (b), (c), and (g) in written form.
11 The information provided in written form may be limited to the
12 geographic region in which the enrollee or potential enrollee resides
13 or intends to reside.

14 SEC. 2. Section 10133.15 is added to the Insurance Code, to
15 read:

16 10133.15. (a) (1) A health insurer that contracts with providers
17 for alternative rates of payment pursuant to Section 10133 shall
18 make available a provider directory or directories that shall provide
19 information on contracting providers, including those that accept
20 new patients pursuant to the requirements of this section and
21 Section 10133.1. A provider directory shall not include information
22 on a provider that does not have a current contract with the insurer.

23 (2) An insurer shall provide the directory or directories for the
24 specific network offered for each product using a consistent method
25 of network and product naming, numbering, or other classification
26 method that ensures the public, ~~enrollees, insureds, potential~~
27 ~~enrollees, insureds, the department, and other state or federal~~
28 agencies can easily identify which providers participate in which
29 networks for which products. An insurer shall use the same
30 consistent classification method in provider contracts and
31 communications to ensure that providers can identify the products
32 and networks that they are legally contracted to provide services
33 in. The classification shall be consistent across ~~plans~~ *products* in
34 order to permit the department and other state or federal agencies
35 to construct multiplan directories.

36 (3) The provider directory or directories shall be available on
37 the insurer's Internet Web site to the public and potential ~~enrollees~~
38 ~~insureds~~ without any requirement that a member of the public or
39 potential ~~enrollee~~ *insureds* indicate intent to obtain coverage from
40 the insurer. The directory or directories shall be available to the

public without requiring that an individual seeking the directory information demonstrate coverage with insurer, provide a policy number, provide any other identifying information, or create or access an account.

(b) (1) The provider directory or directories shall be accessible on the insurer's public Internet Web site through a clearly identifiable link or tab and in a manner that is accessible and searchable by the public, potential-enrollees, ~~enrollees~~, *insureds*, *insureds*, and providers. The insurer's public Internet Web site shall allow for provider searches by name, practice address, National Provider Index number, California license number, facility or identification number, product, tier, provider language, medical group, or independent practice association, hospital, or clinic, as appropriate. If another technology emerges that takes the place of Internet Web sites, the department shall direct the insurer to make the information required under this section available on the subsequent technology in a timeframe that allows for implementation of the technology, not to exceed six months. The insurer shall also make a paper copy of the directory or directories available upon request.

(2) The insurer shall update the provider directory directories, at least weekly, posted pursuant to paragraph (1) with any change to contracting providers, including all of the following:

(A) ~~Instances where~~ *Whether* a contracting provider has notified the insurer that the provider no longer ~~intends~~ *intends* to participate as a contracting provider, is no longer accepting new patients, that the provider moved or relocated from the contracted service area of the ~~plan~~, *product*, or has retired or otherwise ceased to practice.

(B) ~~Instances where~~ *Whether* the contracting provider group, if any, has identified that the provider is no longer associated with the group or is no longer accepting new patients.

(C) ~~Instances where~~ *Whether* the ~~plan~~ *insurer* identified a change based on ~~an enrollee~~ *an insured* complaint that a provider was not accepting new patients or was otherwise not available.

(D) Any other relevant information that has come to the attention of the ~~plan~~ *product* affecting the content of the provider directory.

(3) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the insurer if the provider directory information appears to be inaccurate.

(4) By September 15, 2016, or no later than six months after the date that provider directory standards are developed under subdivision (d), an insurer shall use the developed standards pursuant to subdivision (d) for each product offered by the insurer.

(c) The insurer shall include all of the following information in the provider directory or directories:

(1) The provider's name, ~~location~~, *practice location or locations*, and contact information.

(2) Type of practitioner.

(3) National Provider Identification number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) (A) For physicians, the medical group, if any.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives to the extent their services may be accessed and are covered through the contract with the insurer.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the ~~plan~~, *insurer*, the name of the provider, and the name of the federally qualified health center or clinic.

(7) Hospital admitting privileges, if any, for physicians and other health professionals contracted with the insurer whose scope of services for the ~~plan~~ *product* include admitting patients and who have admitting privileges at a hospital.

(8) Non-English language, if any, spoken by a health professional as well as non-English language, if any, spoken by ~~staff to the provider~~, *the provider's staff*.

(9) Whether a provider is accepting new patients with the product selected by the ~~enrollee~~ *insured* or potential ~~enrollee~~, *insured*.

(10) Network tier that the provider is assigned to, if applicable.

“Tiered provider network” means a network of participating providers that has been divided into subgroupings differentiated

1 by the insurer according to ~~enrollee~~ *insured* cost-sharing levels or
2 quality scores. Nothing in this section shall be construed to require
3 the use of network tiers other than contracting and noncontracting
4 tiers.

5 (11) A disclosure that insureds are entitled to full and equal
6 access to covered services, including insureds with disabilities as
7 required under the Americans with Disabilities Act and Section
8 504 of the Rehabilitation Act.

9 (12) All other information necessary to conduct a search
10 pursuant to subdivision (b).

11 (d) A specialized insurer shall include all of the following
12 information for each of the provider directories used by the insurer
13 for its networks:

14 (1) The provider's name, ~~location(s)~~ *practice location or*
15 *locations*, and contact information.

16 (2) Type of practitioner.

17 (3) National Provider Identification number.

18 (4) California license number and type of license.

19 (5) The area of specialty, including board certification, if any.

20 (6) If participating in a group practice, the name of the group
21 practice.

22 (7) The names of any allied health care professionals to the
23 extent their services are covered through the contract with the ~~plan~~.
24 *insurer*.

25 (8) Non-English language, if any, spoken by a health
26 professional as well as non-English language, if any, spoken by
27 ~~staff~~. *the provider's staff*.

28 (9) Whether a provider is accepting new patients enrolled in the
29 product that the directory applies to.

30 (10) A disclosure that insureds are entitled to full and equal
31 access to covered services, including insureds with disabilities as
32 required under the Americans with Disabilities Act and Section
33 504 of the Rehabilitation Act.

34 (e) (1) By March 15, 2016, the Department of Managed Health
35 Care and the department shall develop a provider directory
36 standards for purposes of paragraph (3) of subdivision (b).

37 (2) The standards shall be sufficient to permit a single uniform
38 electronic directory that would allow a member of the public to
39 determine whether a physician or other provider is available to an
40 ~~enrollee insured~~ of the California Health Benefit ~~Exchange~~ as well

1 as *Exchange*, a beneficiary of the Medi-Cal program enrolled in
2 a Medi-Cal managed care plan. ~~The standards shall be sufficient~~
3 ~~to permit a single uniform directory that would allow a member~~
4 ~~of the public to determine whether a physician or other provider~~
5 ~~is available to an enrollee with group coverage as well as to a~~
6 ~~beneficiary of the Medi-Cal program enrolled in a Medi-Cal~~
7 ~~managed care plan or to an enrollee of the California Health Benefit~~
8 ~~Exchange; plan, as well as to an insured with group coverage.~~

9 (3) The department and the Department of Managed Health
10 Care shall seek input from interested parties, including holding at
11 least one public meeting. In developing the directory ~~template,~~
12 ~~standards,~~ the ~~department and the~~ Department of Managed Health
13 Care shall take into consideration any requirements for provider
14 directories established by the federal Centers for Medicare and
15 Medicaid Services.

16 (f) (1) The insurer shall provide the directory or directories to
17 the department in a format and manner to be specified by the
18 department.

19 (2) The insurer shall demonstrate no less than quarterly to the
20 department that the information provided in the provider directory
21 or directories is consistent with the information required under
22 Section 10133.5 and other provisions of this part. The insurer shall
23 assure that other information reported to the department is
24 consistent with the information provided to ~~enrollees,~~ *insureds*,
25 ~~potential enrollees,~~ *insureds*, and the department pursuant to this
26 section.

27 (3) The insurer shall demonstrate to the department that ~~enrollees~~
28 ~~insureds~~ or ~~potential enrollees~~ *insureds* seeking a provider that is
29 contracted with the network for a particular product can identify
30 these providers and that the provider is accepting new patients.
31 The insurer shall ensure that the accuracy of the provider directory
32 meets or exceeds 97 percent.

33 (4) The insurer shall contact any provider which is listed in the
34 provider directory and which has not submitted a claim within the
35 past three months for primary care providers, or six months for
36 specialty care providers, to determine whether the provider is
37 accepting patients or referrals from the ~~plan,~~ *insurer*, if claims are
38 paid by the insurer. If the provider does not respond within 30
39 days, the insurer shall remove the provider from the provider
40 directory. This requirement does not apply to claims or claim data

1 from new primary care providers in the first three months, or new
2 specialty care providers in the first six months, of the contract.

3 (g) The insurer shall make available an electronic copy of, or
4 upon request, one physical copy of the provider directory or
5 directories to the following:

6 (1) To the State Department of Health Care Services for
7 Medi-Cal managed care plans.

8 (2) To the California Health Benefit Exchange for the networks
9 of the products offered through the California Health Benefit
10 Exchange, as required by contract.

11 (3) On request by the Public Employees' Retirement System,
12 to the Public Employees' Retirement System.

13 (4) The department and the Department of Managed Health
14 Care.

15 (5) On request by a group purchaser, provider directory or
16 directories for the products available in the market segment of the
17 group.

18 (h) If a contracting provider, or the representative of a
19 contracting provider, informs an ~~enrollee insured~~ or potential
20 ~~enrollee insured~~ that the provider is not accepting new patients,
21 the contract between the insurer and the provider shall require the
22 provider to *inform the insurer that the provider is not accepting*
23 *new patients and* direct the ~~enrollee insured~~ or potential ~~enrollee~~
24 ~~insured~~ to the insurer for additional assistance in finding a provider
25 and also to the department to inform it of the possible inaccuracy
26 in the provider directory. If an ~~enrollee insured~~ or potential ~~enrollee~~
27 ~~insured~~ informs an insurer of a possible inaccuracy in the provider
28 directory or directories, the insurer shall undertake immediate
29 corrective action to ensure the accuracy of the directory or
30 directories.

31 (i) This section does not prohibit an insurer from requiring its
32 contracting providers, contracting provider groups, or contracting
33 specialized health care plans to satisfy the requirements of this
34 section. If an insurer delegates the responsibility of complying
35 with this section to its contracting providers, contracting provider
36 groups, or contracting specialized health care plans, the insurer
37 shall ensure that the requirements of this section are met.

38 (j) Every insurer shall ensure processes are in place to allow
39 providers to promptly verify or submit changes to demographic
40 information and participation status. Those processes shall, at a

1 minimum, include an online interface for providers to submit
2 verification or changes electronically and shall allow providers to
3 receive an acknowledgment of receipt from the health insurer.
4 Providers shall verify or submit changes to demographic
5 information and participation status using this process according
6 to the terms of their contract with the insurer.

7 (k) Every health insurer shall allow ~~enrollees insureds~~ to request
8 the information required by this section through their toll-free
9 telephone number, electronically, or in writing. On request of an
10 ~~enrollee insured~~ or potential ~~enrollee, insured~~, the insurer shall
11 provide the information required under subdivisions (a), (b), (c),
12 and (g) in written form. The information provided in written form
13 may be limited to the geographic region in which the ~~enrollee~~
14 ~~insured~~ or potential ~~enrollee insured~~ resides or intends to reside.

15 SEC. 3. No reimbursement is required by this act pursuant to
16 Section 6 of Article XIII B of the California Constitution because
17 the only costs that may be incurred by a local agency or school
18 district will be incurred because this act creates a new crime or
19 infraction, eliminates a crime or infraction, or changes the penalty
20 for a crime or infraction, within the meaning of Section 17556 of
21 the Government Code, or changes the definition of a crime within
22 the meaning of Section 6 of Article XIII B of the California
23 Constitution.